Nashville Consortium of Safety Net Providers

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this Authorization, I, _____, authorize member organizations of the Nashville Consortium of Safety Net Providers (hereinafter "Consortium") to use or disclose my health information as described below.

- ***Information that is covered by this Authorization***. Health information about me that is subject to this Authorization includes all health information about me that is created or received by member organizations of the Consortium, except for the following:

  _____

- ***Entity authorized to use or disclose my health information.*** Matthew Walker Comprehensive Health Center, Centerstone Community Mental Health Centers, Metropolitan Nashville General Hospital, Meharry Medical College, Metropolitan Public Health Department, Comprehensive Care Center, United Neighborhood Health Services, Faith Family Health Center, Baptist Hospital, Buffalo Valley Treatment Center, Centennial Medical Center, Samaritan Recovery Community, Saint Thomas Health Services, Pathfinders Incorporated, Tennessee Christian Medical Center, Mental Health Cooperative, Southern Hills Medical Center, Foundations, Vanderbilt University Medical Center, Meharry-Vanderbilt Alliance, Interfaith Dental Clinic, Siloam Family Health Center, and Catholic Charities of Tennessee (hereinafter "Providers") are authorized to use or disclose health information about me.

- ***Receiver of my health information.*** All Providers are authorized to receive health information about me.

- ***Purpose of use or disclosure of my health information***. Providers are authorized to use or disclose health information about me for the term of this Authorization for the purpose of sharing health information about me for Bridges to Care. Bridges to Care has established an electronic system for the purposes of receiving, storing, and sharing health care information among Providers in order to create a common medical record for me. Since Providers all participate in Bridges to Care, I am authorizing Providers to use, disclose, or receive my health information to or from Bridges to Care or other Bridges to Care providers for purposes of creating or accessing my common medical record.

- ***Term of the Authorization***. This Authorization will remain in effect until the Bridges to Care program no longer serves uninsured persons or unless it is revoked by me.

I understand that once Providers discloses my health information to a third party, any redisclosures of my health information by such third party may no longer be protected under federal or state privacy laws. However, any recipient of information relating to substance abuse may be prohibited from disclosing this substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I understand that I may at any time make a written request to Providers to inspect and/or obtain a copy of my health information and that Providers will within thirty (30) days of receiving this written request, either contact me for a convenient time to inspect and/or copy my health information or provide me with copies or a summary of my health information.

I understand that I may refuse to sign this Authorization at any time for any reason and that my refusal to sign this Authorization will not affect the commencement, continuation, or quality of treatment of me by Providers.

I understand that Providers will not sell or receive compensation for the use or disclosure of my health information.

I understand that I may revoke this Authorization at any time and that such revocation will not affect the commencement, continuation, or quality of treatment of me by Providers. In order to revoke my Authorization, I understand that I should obtain a Revocation Notice from the Privacy Office at the Metro Public Health Department and submit a completed Revocation Notice to the Metropolitan Public Health Department. I understand I may also revoke this Authorization by submitting a request to revoke in writing to the Privacy Office at the Metropolitan Public Health Department. This revocation will be effective immediately upon receipt of the Revocation Form or written request to revoke by Providers, except that the Revocation will not have any effect on action taken by Providers in reliance on this Authorization before it received the Revocation Form or written request to revoke.

I understand that I may contact the Privacy Office for Bridges to Care at:

ADDRESS	Metropolitan Public Health Department; 311 23rd Avenue North, Nashville, TN 37203
PHONE NUMBER	615-340-5679
FAX	615-340-5665
EMAIL	tonya.ruttlen@nashville.gov

I understand that this Authorization will remain in effect until its term expires or I submit a Revocation Form or written request to revoke to Providers at the address listed above.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. Accordingly, I knowingly and voluntarily authorize Providers to use or disclose my health information in the manner described above.

_____ _____

Signature of Patient Date

If Patient is a minor or otherwise unable to sign this Authorization, please complete the information below:

_____ _____ _____

Signature of Authorized Personal Representative Relationship Date

_____

Printed Name of Authorized Personal Representative

_____ _____

Witness Date

A COPY OF THIS SIGNED AUTHORIZATION WILL BE PROVIDED TO PATIENT